

ATHLETIC PARTICIPATION FORM

PARENT/GUARDIAN PERMISSION FOR PARTICIPATION

Your signature below indicates that you have read and agree to the following warnings and conditions:

***WARNING:** Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which any student will engage in or out of school, BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CASTROPHIC INJURY. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk.

*Students in the Denver Public Schools are eligible to participate in a medical, dental, and life insurance program at their own expense if private insurance is unavailable. The building principal or athletic director has the necessary forms.

***PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR OWN EQUIPMENT DAILY.**

***I have read the attached information regarding conduct and academic eligibility with my son/daughter, and understand that athletes must abide by its terms.**

I hereby give my consent for _____ grade _____ to compete in athletics for THOMAS JEFFERSON HIGH SCHOOL in Colorado High School Activities Association approved sports.

Parent or Guardian Signature _____ Date _____

Student Signature _____ Date _____

EMERGENCY INFORMATION

PLEASE PRINT ALL INFORMATION:

NAME OF ATHLETE _____

NAME OF PARENT/GUARDIAN _____

ADDRESS _____

HOME PHONE _____ DAYTIME PHONE _____

OTHER PHONE NUMBERS _____

INSURED BY _____ POLICY# _____

FAMILY DOCTOR _____ PHONE# _____

EMERGENCY CONTACT (1) _____ PHONE# _____

(2) _____ PHONE# _____

IF CONTACT CANNOT BE MADE WITH ANY OF THE ABOVE, THE COACH WILL USE HIS BEST JUDGMENT TO PROTECT AND ASSIST THE INJURED IN ACCORDANCE WITH DENVER PUBLIC SCHOOL POLICY.

ELIGIBILITY CHECKLIST:

Academic: Okay _____ 2.0 Recertification _____ CHSAA recertification _____

Pay for Play: Pd in full _____ Community Service _____ Payment Plan _____ Waiver _____

Physician's Signature Required on the Back

TO BE COMPLETED BY STUDENT AND/OR PARENT

HISTORY

Date _____ Personal Physician _____

Name _____ Sex _____ Age _____ Date of birth _____

Explain "Yes" answers below:

- Have you ever been hospitalized? Yes ☐ No ☐
- Have you ever had surgery? Yes ☐ No ☐
- Are you presently taking any medications or pills? Yes ☐ No ☐
- Do you have any allergies (medicine, bees or other stinging insects)? Yes ☐ No ☐
- Have you ever passed out during or after exercise? Yes ☐ No ☐
- Have you ever been dizzy during or after exercise? Yes ☐ No ☐
- Have you ever had chest pain during or after exercise? Yes ☐ No ☐
- Do you tire more quickly than your friends during exercise? Yes ☐ No ☐
- Have you ever had high blood pressure? Yes ☐ No ☐
- Have you ever been told that you have a heart murmur? Yes ☐ No ☐
- Have you ever had racing of your heart or skipped heartbeats? Yes ☐ No ☐
- Has anyone in your family died of heart problems or a sudden death before age 50? Yes ☐ No ☐
- Do you have any skin problems (itching, rashes, acne)? Yes ☐ No ☐
- Have you ever had a head injury? Yes ☐ No ☐
- Have you ever been knocked out or unconscious? Yes ☐ No ☐
- Have you ever had a seizure? Yes ☐ No ☐
- Have you ever had a stinger, burner or pinched nerve? Yes ☐ No ☐
- Have you ever had heat or muscle cramps? Yes ☐ No ☐
- Have you ever been dizzy or passed out in the heat? Yes ☐ No ☐
- Do you have trouble breathing or do you cough during or after activity? Yes ☐ No ☐
- Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)? Yes ☐ No ☐
- Have you had any problems with your eyes or vision? Yes ☐ No ☐
- Do you wear glasses or contacts or protective eye wear? Yes ☐ No ☐
- Have you ever sprained/strained, dislocated, fractured, broken or had repeated or other injuries of any bones or joints? Yes ☐ No ☐
- Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Foot ☐
- Forearm ☐ Shin/calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hip ☐ Hand ☐
- Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? Yes ☐ No ☐
- Have you had a medical problem or injury since your last evaluation? Yes ☐ No ☐
- When was your last tetanus shot? _____
- When was your last measles immunization? _____
- When was your first menstrual period? _____
- When was your last menstrual period? _____
- What was the longest time between your periods last year? _____

Explain "yes" answers:

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. Date _____

Signature of athlete _____

Signature of parent/guardian _____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

PHYSICAL EXAMINATION

NAME _____ AGE _____ DATE OF BIRTH _____

Height _____	Weight _____	BP _____	Pulse _____
Vision R 20/ _____	L 20/ _____	Corrected: Y N	Pupils _____
Cardiopulmonary	Normal	Abnormal Findings	Initials
Pulses			
Heart			
Lungs			
Tanner stage	1 2 3 4 5		
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

CLEARANCE

- A. Cleared
B. Cleared after completing evaluation/rehabilitation for:
C. Not cleared for:

☐ Collision
☐ Contact
☐ Non-contact

Strenuous _____ Moderately strenuous _____ Non strenuous _____

RECOMMENDATION:

NAME OF PHYSICIAN/PA /NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR: _____

ADDRESS _____

SIGNATURE OF MD/DO, PA, NA, DC-SPC# _____

DATE: _____

PHONE _____